Recommendations Concerning Public/Private Decision-Making Roles and Responsibilities for the New System of Care

Submitted to
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May 7, 2004

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EXECUTIVE SUMMARY

The Decision-making Roles and Responsibilities Recommendations Group (RG) presents to Harry Spence, Commissioner of the Massachusetts Department of Social Services (DSS), eight recommendations that clearly articulate the decision-making responsibilities of DSS Area Offices and lead agencies in the new system of care. The recommendations are the culmination of an intensive nine-week consensus process during which the RG examined a comprehensive series of decision points and the decision-making environment, guided by the Department's commitment to child-driven, family-centered practice. The RG believes that its recommendations will improve the way that DSS and its lead agencies work together in partnership with families to ensure the safety, well-being, and permanency of children.

The RG's mandate to examine decision-making roles and responsibilities grew out of the recommendations of the Department's Procurement Review Workgroup, principally to create 28 area-based lead agencies and six regional resources centers and to hold them accountable for meaningful outcomes. The Workgroup noted that accountability, responsibility, and authority must be granted in equal measure and advised the Department to clearly spell out the extent of decision-making authority that lead agencies would receive. The Workgroup also recommended that lead agencies be charged with creating local integrated service networks using the system of care philosophy and framework. Central to this approach is a strong area-based/community-based service system that cares for and supports children and their families in their community to the greatest extent possible. The Department accepted the Workgroup's recommendations as important strategies for increasing the investment in community-based services and decreasing reliance on residential placements, ultimately leading to increased community tenure and permanency for children. As the new system is designed, it creates opportunities for DSS to rethink the manner in which it engages and works with lead agencies. It was the RG's mission to examine what the decision-making roles and responsibilities could be in this new environment and how those roles could be made clear and actionable. The RG envisions a collaborative team-based approach in which families, DSS staff, lead agencies, and providers share information and ideas, working together to achieve positive, lasting outcomes. Yet within the team, responsibility, accountability and authority must be clear.

This report describes the RG's eight specific recommendations as well as its general recommendations and the assumptions and conditions it sees as guiding both the system of care development and the implementation of its recommendations. The recommendations and observations highlighted below have special significance as the fundamental opportunities and challenges that result from the RG's work.

1. Understanding and supporting the role of families as decision-makers is work that has only just begun and will require much more diligent, collective effort on the part of DSS, lead agencies, and providers in partnership with families. It is clear that there is variation in how "family-centered practice" is defined, understood, and implemented in daily practice both in DSS and in the provider community. One result of this variation is that the role of families in the context of clarifying professional relationships was a key struggle throughout the RG's conversations. However, the RG also believes that engaging in this challenging conversation resulted in important shared thinking that was one of the most valuable results of its work together. The RG strongly recommends that the Department create forums to broaden this conversation.

2. The RG recommends that overall case management responsibility remain with DSS. DSS' expertise in and stewardship for child protection is unique and holds an important place in the child and family service system. However, the commitment to community tenure and permanency requires that DSS not hold on to this role so tightly that it fails to recognize and value the equally important contributions of the provider community and families' own support systems. Finding

the right balance among the contributions of families, providers, lead agencies, and DSS was a constant challenge in the RG's deliberations and will likely remain one as new working partnerships are developed.

3. The RG recommends that lead agencies be authorized to make a full range of service management decisions for some families. The RG sees its recommendations as an evolution, not a revolution, in the design and practice of the service system based on shared continuous learning. The proposed design of the new system of care, including more flexible financing, broadens the array of services that will be integrated in a single network and the possible transitions in service. This, in turns, results in a wider range of decisions that will be made, as well as an increase in the frequency of making them. The new system of care will not limit decisions to those made within a residential network (as in Commonworks) or within a community-based in-home services network (as in Family Based Services). Thus, service management will be a broader responsibility in the new system consistent with the broader array of services available to achieve outcomes.

4. As with the developmental approach that the Department will take with the system of care implementation, the RG recommends that the new roles it proposes be implemented in a staged manner. It has identified two groups of families who it believes will benefit from having lead agencies authorized in a service management role. Prior to initiating even this level of authorization, all Area Offices and their lead agencies must engage in a process to build a strong relationship based on shared values, trust, and open communication. The lessons from the current system indicate that this is fundamental to any type of effective partnership. Once this stage is completed, the lead agency would be authorized to make the full range of service management decisions described below in recommendations two and three.

The RG makes the following specific recommendations:

Recommendation 1 – Overall Case Management: DSS will continue to hold overall case management responsibility. This does not imply making each and every decision. When lead agencies are authorized to make certain decisions, DSS will hold monitoring and quality assurance responsibilities. All decision-making should be done in a collaborative manner with families, lead agencies and service providers.

Recommendation 2 – Service Management For Families Whose Children Are Currently in Long-term Residential Care: Lead agencies should be authorized to make a set of service management decisions for and with families whose children are in long-term residential care but whose safety and well-being they could maintain with the proper services and supports in a community setting. Among the service management decisions are: the selection of specific service models, providers, and community resources to work with a family/family member; the intensity and frequency of service receipt; and changes in service providers working with a family.

Recommendation 3 – Service Management For Families Whose Children Are at Risk of Placement in Long-term Residential Care: Lead agencies should be authorized to make a set of service management decisions for and with families whose children are at risk of placement in long-term residential care but whose safety and well-being they could maintain with the proper services and supports in a community setting. Among the service management decisions are: the selection of specific service models, providers, and community resources to work with a family/family member; the intensity and frequency of service receipt; and changes in service providers working with a family.

Recommendation 4 – Service Coordination: For families who are receiving services through the lead agency's service network, the lead should be authorized to make certain decisions, but not the full range that comprise service management. The children and families served include all those not identified in the previous two recommendations, e.g., children who should remain in long-term residential care, families caring for their children at home with no risk of long-term care, families needing only a single service.

Recommendation 5 – Educational Coordination in Relation to the Well-being of Children: Authority for educational decision-making will depend not only on whether the child is in the Department's care or custody, but on the type of educational program or services the child receives. Parents must be involved in many instances when special educational decision-making and advocacy take place. Even where not legally required, they should take part in educational matters involving their children whenever possible. The RG sees great benefit in the lead playing a central role in collaborating and coordinating with parents to achieve the greatest educational outcomes for children.

Recommendation 6 – Service Plan & Service Plan Revisions: Establishing and revising Service Plans should be a collaborative process with families and lead agencies, with ultimate responsibility resting with DSS. The lead agency should play an important role in making recommendations to DSS and, when requested by DSS, convene the team for treatment planning in order to access purchased services and/or community resource aspects of the service plan.

Recommendation 7 – Change or consideration of change in the care and custody of a child: DSS should make decisions concerning the change, or consideration of change, in the care and custody of a child because of the Department's knowledge and experience in carrying out its protective mandate, as well as court involvement/approval.

Recommendation 8 – Return of Custody, Permanency, and Case Closure: DSS should make decisions concerning the return of custody, permanency and closure of a case because they are based on significant risk assessment decisions, are supported by legal counsel, and may need court approval.

The RG's final recommendation relates to the process by which it fulfilled its mission. The RG found that committing sufficient time to step away from the immediate press of their work enabled them to understand the assumptions, values, and strengths that each member brought to the table. Focusing on specific analytic work with the goal of producing recommendations for a specific purpose allowed the conversation to explore philosophical and value-laden issues in a grounded manner firmly connected to the reality of daily practice. The RG found that the interplay between the family representatives, providers and DSS staff resulted in greater understanding and more innovative thinking. The end result was that the group became a community of practice, having built shared knowledge and expertise.

The RG believes that these recommendations will improve the way DSS and lead agencies work together to ensure the safety, well-being and permanency of children. In conjunction with the assumptions and general recommendations, they articulate decision-making roles and responsibilities in a way that will enhance the long-term success of the system of care.

I. Introduction

This report presents the recommendations of the Decision-Making Roles and Responsibilities Recommendations Group (RG). Comprised of 26 representatives from the Department of Social Services (DSS), private providers, and family representatives, the RG undertook a comprehensive consensus-building process, meeting in intensive day-long sessions over a nine-week period.

DSS Commissioner Harry Spence charged the RG to make specific recommendations about the decision-making roles and responsibilities between DSS and lead agencies that should be designed within the to-be-implemented system of care. He stressed that the recommendations should be founded on the Core Practice Values of: child-driven; family-centered; community focused; strength based, committed to diversity/cultural competence, and committed to continuous learning.

The need to clearly articulate decision-making roles was first identified by the Department's Procurement Review Workgroup in their final report (issued in April 2003 and available on the DSS website). That Workgroup presented recommendations for designing, managing, and purchasing local integrated service networks, using the system of care philosophy and framework. DSS will redesign and reprocure its current categorical services of Commonworks, residential treatment and group homes, contracted foster care, and family-based services based on the Workgroup's recommendations. DSS accepted the Workgroup's recommendation to contract with providers to establish 28 area-based lead agencies and six regional resource centers. It also accepted the recommendation to hold lead agencies more accountable for outcomes than has previously occurred.

The policy matter of how much decision-making authority DSS would grant to lead agencies and the degree to which DSS could hold them accountable has evolved since it was first identified by the Procurement Review Workgroup. It is important to review where the RG began and how its conversations and learning evolved.

When the Procurement Review Workgroup recommended that lead agencies be held accountable for outcomes, they also stated that responsibility, accountability, and authority must be granted in equal measure. It is unreasonable to ask a lead agency to achieve a certain outcome but not allow them to make any decisions required to do so. The Workgroup also noted that it was interested in holding lead agencies accountable for outcomes that are meaningful for families and communities—outcomes related to safety, permanency, and well-being. As DSS considered how best to address the questions related to this policy matter, it saw that there could be benefits to clearly defining decision-making roles. These benefits include preventing DSS and lead agency staff from duplicating their efforts as well as eliminating any gaps in their efforts in working with families. Ideally, the definition of roles would be based on the strengths that DSS and lead agencies bring to the table in ways that best support families.

Consistent with its approach to other initiatives, DSS viewed the challenge of clarifying decision-making roles as an opportunity to engage in an intensive conversation with many voices and perspectives represented. It also recognized that the issue of who makes what decisions, and for and about whom, would require examining a range of complex questions. Such a discussion would have to uncover several layers that define views of casework: philosophy and values; regulation and policy; operational procedures; and field reality and daily practice. With the advice of the Massachusetts Office of Dispute Resolution (MODR), a consensus-building process was chosen. A planning group then interviewed several consensus-building facilitators, selecting William DeVane Logue to design and lead a process that was honest, rigorous, and transparent. In the fall of 2003, Logue held in-depth meetings with DSS and conducted over 50 interviews with DSS staff, private providers, families and youth throughout the state.

He presented his findings and recommendations in the "Assessment Report on the Feasibility of a Roles and Responsibilities Consensus-Building Process" (issued December 31, 2003, and available under System of Care at www.state.ma.us/dss).

In comprising the RG membership, DSS felt it was important to hear from the broadest possible range of internal voices. The conversation about decision making doesn't start from a blank slate. Currently, DSS holds a great deal of power in this area. It recognized that the challenge in addressing the questions of how much, under what circumstances, and with whom it would share this power would likely lie within the Department. However, it was also aware that having external perspectives at the table would help spark new thinking and innovative ideas. Thus, the RG membership included representatives of provider agencies and families. True to expectations, this mix of internal and external perspectives and experiences did indeed bring forward new ideas. Perhaps the most fundamental and powerful change the RG made was to broaden the original question about how professionals working in the public child welfare agency and in provider agencies should be joined in a contractual and accountable relationship.

While the RG understood its charge to look at the decision-making roles of DSS and lead agencies, they questioned where and how family voices would be heard and respected. Because they were committed to holding true to the value of child-driven, family-centered practice and the central role of families as decision-makers, the role of families in the context of clarifying professional relationships was a key struggle. It also became clear that there is variation in how family-centered practice is defined, understood, and implemented in daily practice. The RG's views about how family-centered practice informs decision-making appear throughout their recommendations. Fundamentally, they believe that families have a primary interest and investment in the safe, healthy, successful growth and upbringing of their children.

To extend both the range of perspectives as well as the lines of communication, three separate advisory councils were established – the Family Advisory Council, the DSS Advisory Council, and the Provider Advisory Council – to provide advice and contribute to the learning of the RG. Representing cross-sections of their stakeholder categories, the Provider Advisory Council and the DSS Advisory Council had approximately 30 members each, and the Family Advisory Council had ten members. This open and inclusive approach enriched the process by tapping into a deep reservoir of knowledge and expertise.

The RG realized that it had to expand the initial question out beyond the "professional helping agencies" to a new place with families at the center in order to fully and properly understand the meaning and value of authority and accountability. This conversation was at times uncomfortable; however, the process provided a forum for RG members to talk with each other honestly and productively. From these deliberations, the RG has produced specific recommendations for consideration for the lead agency's decision-making role in the system of care. The recommendations presented here address the original charge regarding lead agencies, but they also highlight specific roles of families (mindful that the RG was not charged with examining case practice).

II. Overview of the Process

The RG's work included reaching agreement on ground rules for the discussions; establishing criteria for evaluating recommendations; identifying the interests of the stakeholder groups; engaging in a responsibility charting process to assist in the identification of decision-making roles and responsibilities; developing underlying assumptions and conditions; discussing possible options for recommendations, and

narrowing the recommendations to those contained in this report. At several points, RG members met with the three advisory groups to keep them apprised of their progress and to obtain input and feedback.

Ground Rules and Roles: Ground Rules addressed process goals, representation and roles, RG member responsibilities, decision-making process, communication, distribution of materials, record of meetings, role of work groups, media, and role of the facilitator. The RG agreed that the final report to the Commissioner would show the areas of consensus as well as capture important elements of the discussion so that he could make an informed decision. Further, they noted that some opinions and recommendations might require additional action, such as revision to policies and procedures, or negotiation in other forums such as the collective bargaining process. The RG agreed that their recommendations would not supplant those other forums.

At several points in the process, the RG took time to reflect on what they had learned from each other. The interplay and complexity of their work, the system of care design, and clinical practice were constant themes. In addition, the need to be attuned to issues of implementation for families, DSS staff and providers was seen as essential to long term success. Concerns were also voiced about privatization, the role of the social worker, and the importance of deepening the clinical work of DSS staff. The economic viability and stability of small and multi-cultural providers were also raised as concerns. So too was the dilemma that in a universe of limited dollars, the provision of intensive, quality care to one family decreases the ability to provide services to a larger number of families.

Stakeholder Interests: The RG identified stakeholder interests of DSS, lead agencies and families so as to understand each other's perspectives and beliefs regarding roles and responsibilities in the new system of care. A partial list is in the accompanying box. A fifth category, mutual interests relating to the system of care, did not relate directly to the focus of the RG but was noted for the procurement planning process. Among the interests listed were achieving cultural competency and improving community capacity.

Chief among mutual interests were:

- Improved services and outcomes for children and families
- Co-location of accountability, responsibility and authority
- Clarity in roles and responsibilities
- A supportive team-based process
- Elimination of delays between decisions made and implementation
- Efficient use of time and resources by avoiding duplication of effort
- Job security for DSS and provider staff

Chief among DSS interests were:

- Manageable workloads for staff to reduce stress and enhance interactions with families
- Confidence in a healthy provider community so that staff can coordinate their work with purchased services and increase the quality of their interactions with families who receive no purchased services
- Meets the core values of DSS
- Balances risk management with allocation of responsibility and authority

Chief among lead agency interests were:

- Right fit of accountability and authority and the alignment of financial risk with accountability
- Clear definitions and delineations so that providers/DSS staff understand what services are contracted for and what outcomes are expected
- Ability to influence network providers who are co-responsible or have been delegated responsibility to implement a decision and/or service
- Have access to DSS staff and managers at appropriate levels to involve them in decision making or resolve individual clinical or systemic issues

Chief among family interests were:

- Participation in decisions that impact their lives in an environment that is non-threatening, with jargon-free language, and a transparent process.
- Have a designated individual who they can contact when a crisis occurs

Criteria for Evaluating Recommendations: The RG members reached consensus on Criteria for Evaluating Recommendations which included: Integrity, Efficiency/Effectiveness, Variability, Usability, and Feasibility. (See Appendix B. for full list.) The criteria were agreed upon early in the process to assist in discussing and evaluating recommendations.

Responsibility Charting: To aid in focusing and illuminating the discussion about the various decision-making roles in the system of care, the RG engaged in a responsibility charting process. Responsibility charting is a method that generates information about the understanding of which player in the partnership has what kind of responsibility about certain decisions. It was used in conjunction with six brief case scenarios that represented a range of family situations including three protective, two CHINS, and one voluntary. The scenarios and process were designed to stimulate conversation about how and by whom critical decisions could be made in the fully implemented system of care, and the implications for roles, responsibilities, accountability and authority.

The RG chose the following seven codes for the responsibility charting: D/Decides, R/Recommends, IM/Implements, C/Consulted, I/Informed, DK/Don't Know, blank/no relationship. (See Appendix C. for definitions.) The RG agreed that it was important to focus on determining who was the critical decision maker, therefore, charting multiple decision makers for a single decision point would not bring the clarity needed for the recommendations. There was much discussion about how to address the extreme importance of the role of the family while also making recommendations relevant to the Request for Responses (RFR) and the procurement of services by DSS through a lead agency. Given the context of the RFR, the group decided to be vigilant about the role of the family as a central decision maker while focusing on the delineation of responsibility for decision-making between DSS and lead agencies.

Decision Point Assumptions and Parameters: The RG delineated crucial decision points (noted in the box at right). In addition, starting assumptions and parameters for confirming the decision points were:

- Families are included as primary partners in all decision-making.
- One of the principles of the system of care is to connect families to services as early as possible in their involvement with DSS.

Decision Points

1. Establish:
   a. service plan goal
   b. outcomes
   c. tasks
2. Change (or consideration of change) in custody or care of child.
3. The selection of specific service models, providers, and community resources to work with a family/family member.
4. Determination of type, level and scope of educational advocacy in relation to well-being of child.
5. Determination of type, level and scope of medical advocacy in relation to well-being of child.
6. For each service, the intensity and frequency of service receipt.
7. Changes in service providers working with a family/family member.
8. For out-of-home placement:
   a. the specific provider,
   b. level of care,
   c. location (initial placement and any subsequent changes).
9. For children placed out of their home:
   a. nature and extent of visitation and contact
   b. short-term trial visit for purpose of transitioning to permanent family
10. For children in their home, short term respite in out of home settings.
11. For each service, duration and termination, whether because of success or ineffectiveness.
12. Changes to:
    a. service plan goal
    b. outcomes
    c. tasks
13. Return custody of child to his/her family.
14. Terminate parental rights.
15. Establish permanency plan.
16. Identify a permanent caretaker resource.
17. End DSS involvement.

- The decision to refer families to the lead agency to access the service network (which includes a range of community and purchased services) can and will occur at several points in the DSS casework process, including investigation, assessment, and ongoing case management.
- The purpose of the RG is not to examine/re-engineer DSS' casework processes (there is a separate significant effort in development to do just that).

Analysis of Results and Development of Options: After the completion of the responsibility charting, the results were analyzed, enabling the RG to see how opinion varied by scenario and decision point, where patterns emerged, and where additional assessment was necessary. This information was used to launch a discussion of possible options for recommendations and to help identify issues impacting decision-making roles including: the courts requiring a certain course of action; whether lead agencies or network providers would have to go to court; the difference between family referral and child referral; allocation of money once a case goes from DSS to lead; what happens when risk escalates, etc. Other issues were privatization, capacity, trust, and finances. It also demonstrated where DSS will need to address issues in the system of care design and clinical practice. At this point in the process, the facilitator drafted a document, called a single text, containing the recommendations believed to have the strongest support and noting where further discussion was necessary. This document went through several iterations as the RG grappled with the content and wording of each section to attain greater depth and clarity. They were mindful that the final document would be read by a wide range of readers. Therefore, the recommendations had to be understandable and supported by the RG's rationale.

III. Definitions

In order to advance its learning as a group and to craft its recommendations, the RG developed shared definitions of the following key terms and concepts:

Decision maker: Given its charge to inform the system of care procurement, the RG defined decision-making in a strict manner. The individual in this role determines and selects the best option; signs off on implementation of the final decision; and is accountable for the quality of the decision. In assigning decision-making roles between DSS and lead agencies, the RG pushed itself to choose one in order to make the points of accountability as clear as possible. However, the RG members believe strongly that the best decisions are those made collaboratively.

The aim of an effective partnership in decision-making is a collaborative, consensus based, team environment, including but not limited to family, kinship network, lead agency, providers and DSS. Teams work best when roles are clear and the party responsible for making the decision in the absence of consensus is clearly identified.

Consensus: Consensus occurs when those participating in a decision-making process agree with a proposed action, plan, recommendation or conclusion and that they can support it, articulate it to others who have not participated in the decision-making process and agree not to oppose the consensus of the group. In addition to using this process for its own work, the RG sees consensus decision-making as an important element of effective case practice. However it also recognizes that timeliness, work responsibility or differences of opinion may make consensus not feasible. Thus, it is critical to have a clearly identified decision-maker.

Team: Consensus and team decision making lead to better clinical decisions, communication, and shared responsibility. Teams include but are not limited to family, kinship network, lead agency, providers and DSS.

Family: The definition of family extends beyond the traditional notion of the biological nuclear family unit to include the family constellation as defined by the family itself and may include kin relationships, parent partners and others in the personal support system available to each family. It also includes foster families and adoptive families. Family networks can join parents in thinking through the best solutions for their children and can assist and model decision-making by parents who at that moment in time are not capable of making decisions. This definition of family also includes youth with no other family connection whose permanency plan is to live independently, ideally with the sustained support of a caring adult.

Case Management: For purposes of the RG's deliberations and this report, case management refers to all decisions made within a case following DSS' decision to open a case based on its investigation and/or assessment work through to closure. The decisions include the 17 listed on page 4.

Service Management: This is the full set of decisions that relate to the management of services (both purchased and non-purchased services). Granting lead agencies this full set of decisions allows them to develop a complete range of options to best support children and their families and achieve meaningful outcomes. The effective selection and implementation of appropriate options requires establishing flexible financial structures. Aligning financial structures with decision-making authority and accountability for outcomes is a critical principle of the system of care design.

Service Coordination: Coordinating services is a "softer" decision-making role than service management in that there are more caveats and qualifiers attached to the authority granted to a lead agency. While some specific service-related decisions are granted to a lead agency, others are not. As a result, the outcomes to which a lead agency could be held accountable are more constrained than when granting leads full service management authority.

IV. Assumptions and Conditions for Implementation

In arriving at recommendations, the RG made a number of assumptions about underlying issues and the context for decision-making roles and responsibilities related to the new system of care. The RG also reached consensus that certain conditions must exist before implementation of the recommendations can be effective. The RG is acutely aware that clinical practice and the design of the system of care are being addressed elsewhere in DSS; issues relating to the design were noted but are not reported here. DSS will establish mechanisms for cross-fertilization of ideas across the RG and system of care design, including some shared membership and future presentations of the emerging design to the RG members.

- **Family-Centered Practice:** DSS is committed to a child-driven, family-centered practice as a core value. Families should be full partners in the decisions affecting them. The RG recognized that this value is universally held although not consistently implemented. When in its role as a public child protection agency DSS must make decisions on behalf of a parent, those decisions should be clearly and respectfully communicated.

- **The Mission of DSS:** A constant thread in all the RG discussions was the challenge of striking a healthy balance between the focus on safety and the focus on permanency. It is easy to view

safety as the issue and concern that trumps all others. However, the RG recognized that permanency in all its forms is an ever-increasing focus of DSS. It also recognized that safety is the most frequent and compelling threat to permanency and that DSS has a unique role and stewardship for child safety. As a result, the level of risk and type of custody play a central role in the comfort level for authorizing other parties to make decisions. The fact that DSS has taken protective custody implies that there has been a substantiation of significant risk. These situations often create an oppositional relationship with families where DSS assumes (for a period of time) the responsibility to make many of the decisions normally made by the parent. While this situation exists, there is increased accountability to the courts. Therefore, many RG members felt that it is difficult to authorize a significant level of decision-making to others.

- **System of Care Development:** DSS has committed to at least a three-year developmental process for realizing its vision for a fully functioning system of care. The RG understood that DSS will establish, as part of the planning and implementation process, mechanisms for ensuring continuity of services. DSS has established an environment of continuous learning from which lessons may emerge that may modify aspects of the system of care design.

- **Job Protection:** The RG recognizes that this process was not intended to—nor should it lead to—job loss through privatization or any other mechanism.

- **Benefits to DSS Clinical Practice:** There are a number of benefits that may come from clarifying decision-making roles and responsibilities. These include a collaborative team-based approach that, especially at the beginning of a family's involvement with DSS, may offer improved and timely matching of services to the needs of the child and family, reducing the need for crisis intervention and removal of a child from their family. It also fosters a supportive environment and more rounded expertise for making inherently difficult decisions and thereby reduces stress. With the lead making certain decisions, DSS social workers may increase their ability to achieve better and more meaningful case practice.

- **Resources and Other Environmental Factors:** DSS' budget for purchased services is limited such that not every family will receive a purchased service. Even if the new service networks are expanded to include a broader range of informal, non-purchased services, there will still be families involved with DSS who will not interact with lead agencies and service networks. The RG also recognizes that resources and other environmental factors make more difficult the issues surrounding decision-making authority and responsibility. In the current funding environment, new funding for additional staffing or services is unlikely in the near term. Scarce resources for purchased services and the time of DSS staff must be allocated judiciously in a planned manner and during times when a family is in crisis.

- **Front Door Services:** There is great hope that in full implementation the lead agencies can participate early in the interaction of a family with DSS and can be a partner to DSS in maintaining intact families and reducing the use and length of out-of-home placements.

- **Preventive Services:** The potential long-term success of the recommendations is enhanced by the development and use of preventive services as well as stronger community resources not contracted through DSS.

- **Monitoring and Quality Assurance:** DSS will need to establish monitoring and quality assurance procedures to address individual case decisions and outcomes on an on-going basis. It

must also develop a means to gather and assess feedback from the families on both the effectiveness of services and their satisfaction with service delivery. The RG anticipates that DSS will articulate the specific outcomes it seeks from the system of care in the domains of client outcomes, system outcomes and process outcomes. (See attachment G of the Procurement Review Report.) Reliable measures of outcomes must be established and contracted for to assure that expectations of all parties are understood. Leads and providers should engage in a Continuous Quality Improvement (CQI) process that parallels and is integrated with the one used by DSS and addresses the relationship issues between DSS, the lead, network providers and families.

- **Legal Work:** The legal work of DSS will continue to be performed by DSS counsel. To the extent lead agencies and providers are involved in decision-making as well as service delivery, DSS counsel must have access to staff and records of the lead agency and providers equivalent to access to DSS staff. Likewise, lead agencies and providers will need access to DSS counsel for consultation.

- **Other decision-making influences and players:** There are other decisions that are influenced by those over whom DSS has no control, including the courts, sister agencies and local educational agencies. The RG is hopeful that the Commissioner and others will engage in dialogue to educate and influence these other players such that the recommendations may be understood and effectively implemented.

V. Decision-Making Roles and Responsibilities Recommendations

General Recommendations

The RG has a number of general recommendations upon which the successful implementation of its specific recommendations depend. Some of the general recommendations must be implemented through the system of care design; others through case practice.

- **Family Focus:** The commitment by DSS to child-driven, family-centered practice requires that lead agencies focus on supporting the entire family in order to facilitate effective clinical decisions. Lead agencies and providers inform and support families in order to promote effective decision-making and strengthen the family's ability to provide care and nurturance to their children.

- **Family Contacts:** Through what it has learned from the family representatives and the Family Advisory Council, the RG recommends that while a team approach can make for better clinical interventions, it is essential from the family's perspective, especially in times of crisis, that they not be overwhelmed by the number of people with whom they need to interact. They need to know their chief contact, be it the DSS social worker or a staff member in a lead agency. However, the family may contact whomever they choose or are most comfortable with, whether it is the DSS social worker, the lead agency or a provider in the network. It would then be the responsibility of the person contacted to communicate with the rest of the team.

- **Risk Assessment Practice**: Much of the discussion of the RG centered on the issue of risk. The degree to which the RG feels comfortable authorizing lead agencies to make decisions relates

directly to the level of risk and the ability to continuously assess the potential for harm that may require protective intervention by DSS. The potential for a reduction or increase in risk with little or no warning is present in almost every family depending on the situation. For these reasons, the RG recommends that leads and their network of providers share and be trained in a common risk assessment practice that will be developed by DSS. This common understanding of the level of risk, how it is identified, and the language used to describe it are essential to effective communication and collaboration and a trusting relationship. It will indicate clearly the protective thresholds that, when reached, would require DSS to play either a greater role or to entirely assume decision-making responsibility.

- **Tools and Mechanisms for Gathering and Sharing Information:** Tools and mechanisms for gathering and sharing information in a timely and efficient manner which are consistent across the state will need to be established. Documentation of decisions external to DSS should be consistent with that of DSS. For example, a single statewide referral form should be implemented so that all team members may share that information. This will assure that those who need to be consulted have the appropriate information and that decisions are communicated to those who must be aware of them. This may be enhanced by lead agency or provider access to appropriate portions of FamilyNet.

- **Timely Dispute Resolution Processes for Reviewing Disagreements:** Families, providers, lead agencies, and DSS need a clear and timely process for resolving disputes. The process must be procedurally fair, allowing for those who made the decision and those with clinical expertise to voice the basis of the decision. The expectation is that this process should be a *last resort and rarely used* in a collaborative environment. Its use can have a negative, disempowering impact concerning decision-making as well as the potential for the undermining of trust. The RG recognizes that DSS and lead agencies will need to advise their staff on how to access and use the dispute resolution process. Furthermore, a method needs to be designed whereby families are informed about the process and have access to it. DSS must also clarify how the dispute resolution process is integrated with, supplements, or replaces existing dispute resolution processes such as the Clinical Review Team.

  Any sub-delegated decision-making by the lead agency to a network provider where the lead and the provider have a formal contractual relationship is the lead agency's responsibility.

  Where a team member from DSS or a lead agency has participated in a decision-making process in which no consensus has been achieved and disagrees with the decision maker and has first raised the issue with the team, the following steps apply:

  - The party who disagrees with the decision will express the nature of disagreement and a request for reconsideration by the decision maker.
  - If this reconsideration does not resolve the issue, it will be referred to the next higher level of management at both DSS and the lead agency for review and consensual resolution.
  - If this does not resolve the disagreement, the person in the next higher level of authority in the organization with the initial decision-making responsibility will consult with his/her counterpart (area director, lead agency director), and then will make a final determination. It is important to note that the dispute resolution process does not shift the responsibility for the decision from the organization with the initial decision-making responsibility.

Furthermore, a system must be in place to examine disagreements and the use of the dispute resolution process so that apparently isolated issues which are symptomatic of structural, design or administrative issues are addressed at the systems level and are linked to the CQI process. Observations and lessons would be applied and corrections in processes and communications would be made at the systems level.

- **Staged Implementation:** The RG discussed the readiness requirements for both lead agencies and Area Offices. Drawing on lessons of current lead agency models, it identified an initial stage composed of team meetings and mutual exploration of issues and shared values during which relationships are developed, trust is built and roles further clarified between each Area Office and their area lead. Once this foundation is established, the lead could increasingly take on the level of authorized decision-making envisioned in the recommendations. Over time, the lead should develop step-down ability, wrap-around services and other supports to help a child remain in the home and/or integrate the child into the community. Different areas may start at different stages based on the skills and knowledge of lead agencies, particularly with respect to the types of cases with which they have limited experience. One way this could be accomplished would be through joint training. The RG anticipates that lead agencies could be authorized to make service management decisions regarding certain populations of children at the start of the system of care. Authorization would be predicated on the lead demonstrating integrated knowledge, practice and training concerning residential, therapeutic foster care, and family-based services. Some leads could demonstrate this at the start of the system of care, while others would require a developmental stage prior to receiving this authorization. DSS should develop and define measures and indicators of readiness relating to the level of authorized decision-making in these recommendations.

Specific Recommendations

RECOMMENDATION 1: Overall Case Management

DSS will continue to hold overall case management responsibility. This does not imply making each and every decision. When lead agencies are authorized to make certain decisions, DSS will hold monitoring and quality assurance responsibilities. All decision-making should be done in a collaborative manner with families, lead agencies and service providers.

The RG believed that it had an opportunity and obligation to "push the envelope" and to ask whether there are situations in which a lead agency might be authorized to make all the decisions that it examined (identified earlier in this report). The RG knew that stakeholders would benefit from its efforts to examine this complex question.

The consensus was that overall case management should remain with DSS and not be delegated to lead agencies. Some of the benefits are that DSS can provide continuity over time; has a comprehensive overview of all aspects of the case; and can build sustained relationships with families. For some members of the RG, this recommendation is made without qualification and with no suggestion that it be revisited. For other members, this recommendation is for the beginning of the system of care with the hope that it can be revisited as the system of care develops. If it were to be revisited, the following factors (among others) would have to be carefully considered:

- Mechanisms to address DSS responsibilities concerning serious protective issues. One such mechanism would be a monitoring system that sets out the parameters for DSS intervention or return of a case to DSS.

- Management and operational infrastructure requirements of lead agencies, including maintaining required staffing levels, and training.

- Assurances and protections that this is not a first step or precedent leading to privatization or job loss for bargaining unit employees.

RECOMMENDATION 2: Service Management For Families Whose Children Are Currently in Long-term Residential Care

Lead agencies should be authorized to make the set of service management decisions listed below for and with families whose children are in long-term residential care but whose safety and well-being they could maintain with the proper services and supports in a community setting.

DSS will refer families to the lead for this type of service based on an assessment that the youth could be ready to return home and the family/caretaker could be ready to care for the child at home if appropriate services could be provided through the lead agency's service network. In addition, an appropriate safety plan would need to be developed to minimize potential risk to the youth, family, and community. The decision to refer a family for this service should not be dependent on the type of case or custody.

Service Management is defined as including the following decisions:

- The selection of specific service models, providers, and community resources to work with a family/family member.
- The intensity and frequency of service receipt; changes in service providers working with a family/family member; and, for each service, duration and termination, whether because of success or ineffectiveness.
- For out-of-home placements, the provider, level of care and location.
- Short-term trial visits for purpose of transitioning to a permanent family.
- The frequency and location of visitation with the family or intended caretaker. DSS will retain the authority for deciding whether visitation must be supervised.
- Educational advocacy for children in DSS custody.

The Role of the Family:

In partnership with the lead agency and its provider network, the family will:

- Identify its own strengths and resources
- Identify its service needs
- Identify kinship networks and community resources
- Help select appropriate service providers and community resources
- Provide feedback on quality of services provided

The Role of the Lead:

The RG sees this recommendation as being an important starting point for the system of care. Only by authorizing lead agencies for this full set of decisions can DSS hold lead agencies accountable for meaningful outcomes in a fair way. Authorizing this full set of service management decisions also creates the opportunity to establish more flexible funding and rate structures in the RFR. The RG has noted that the financial structure (whether an episode of care or case rate, etc.) must be designed carefully to support, not undermine, the lead agency's ability to make the best clinical decisions. Aligning financial structures with decision-making authority and accountability for outcomes is a critical principle of the system of care design.

In identifying this family situation, the RG was mindful of the following goals of the system of care:

- Community tenure and permanency are priority outcomes
- Increasing investment in community-based services through decreasing reliance on residential placements

When the system of care is implemented, there will be new flexibility and capacity to provide a richer array of wraparound services than is currently available. The RG believes (and sees concurrence with the recommendations of the Community Connected Residential Services Workgroup) that there are a number of children who are or will be in residential care at the time the system of care is implemented who could return to their family and community with these new supportive services.

In order to successfully support these families and help achieve positive outcomes for children, leads would need to have within their service networks a full array of services, including intensive family supports, coaching for managing challenging behaviors, youth mentoring, etc. Identifying the specific services would be done in partnership with the family and would be guided by their assessment of what they think it will take to maintain their child's safety and well-being.

DSS plans and promotes regular and frequent visitation for children-in-care and their parents and siblings. The lead, in consultation with the family if appropriate, will be authorized to make decisions concerning the location and frequency of visitation. DSS will retain the authority for deciding whether visitation will be supervised. The lead will be responsible for providing that supervision either directly or through one of its network providers. When appropriate, the lead can recommend to DSS that it end the supervision requirement.

RECOMMENDATION 3: Service Management For Families Whose Children Are at Risk of Placement in Long-term Residential Care

Lead agencies should be authorized to make the set of service management decisions listed below for and with families whose children are at risk of placement in long-term residential care but whose safety and well-being they could maintain with the proper services and supports in a community setting.

Service Management is defined as including the following decisions:

- The selection of specific service models, providers, and community resources to work with a family/family member.

- The intensity and frequency of service receipt; changes in service providers working with a family/family member; and, for each service, duration and termination, whether because of success or ineffectiveness.
- For out-of-home placements, the provider, level of care and location.
- Short-term trial visits for purpose of transitioning to a permanent family.
- The frequency and location of visitation with the family or intended caretaker. DSS will retain the authority for deciding whether visitation must be supervised.
- Educational advocacy for children in DSS custody.

The Role of the Family:

In partnership with the lead agency and its provider network, the family will:

- Identify its own strengths and resources
- Identify its service needs
- Identify kinship networks and community resources
- Help select appropriate service providers and community resources
- Provide feedback on quality of services provided

The Role of the Lead:

The RG sees this recommendation as being an important starting point for the system of care. Only by authorizing lead agencies for this full set of decisions can DSS hold lead agencies accountable for meaningful outcomes in a fair way. Authorizing this full set of service management decisions also creates the opportunity to establish more flexible funding and rate structures in the RFR. The RG has noted that the financial structure (whether an episode of care or case rate, etc.) must be designed carefully to support, not undermine, the lead agency's ability to make the best clinical decisions. Aligning financial structures with decision-making authority and accountability for outcomes is a critical principle of the system of care design.

In identifying this family situation, the RG was mindful of the following goals of the system of care:

- Community tenure and permanency are priority outcomes
- Increasing investment in community based services through decreasing reliance on residential placements

When the system of care is implemented, there will be new flexibility and capacity to provide a richer array of wraparound services than is currently available. This capacity could benefit the families whose children are at risk of residential placement but who could care for them at home if they had access to the appropriate services. Children identified as at risk of long-term residential placement are sometimes at home, but other times in a short-term placement setting, such as a hospital, shelter, or Bridge Home. The RG noted that the age of the child at risk of placement does not affect this recommendation.

In order to successfully support these families and help achieve positive outcomes for children, leads would need to have within their service networks a full array of services, including intensive family supports, coaching for managing challenging behaviors, youth mentoring, etc. Identifying the specific services would be done in partnership with the family and would be guided by their assessment of what they think it will take to maintain their child's safety and well-being.

DSS plans and promotes regular and frequent visitation with children-in-care with parents and siblings. The lead, in consultation with the family if appropriate, will be authorized to make decisions concerning the location and frequency of visitation. DSS will retain the authority for deciding whether visitation will be supervised. The lead will be responsible for supervision either directly or through one of its network providers. When appropriate, the lead can recommend to DSS that it end the supervision requirement.

RECOMMENDATION 4: Service Coordination

For families who are receiving services through the lead agency's service network, the lead should be authorized to make certain decisions as identified and discussed below. The children and families served include all those not identified in the previous two recommendations, e.g., children who should remain in long-term residential care, families caring for their children at home with no risk of long-term care, families needing only a single service.

Coordinating services is a "softer" decision-making role than service management in that there are more caveats and qualifiers attached to the authority granted to a lead agency. While some specific service-related decisions are granted to a lead agency, others are not. As a result, the outcomes to which a lead agency could be held accountable are more constrained than when granting leads full service management authority. The system of care design process must establish criteria for referring families to lead agencies and their service networks. The RG recognizes that the exact level of decision-making authority that a lead agency could exercise depends on their level of involvement with a family and the extent to which they know the family's situation. The RG was particularly concerned about having final decision-making authority rest with leads in situations where safety concerns and risk are high.

The Role of the Family:

In partnership with the lead agency and its provider network, the family will:

- Identify its own strengths and resources.
- Identify its service needs.
- Identify kinship networks and community resources.
- Help select appropriate service providers and community resources.
- Provide feedback on quality of services provided.
- Make recommendations on respite. If the family has custody, it makes decisions on respite with the assistance of the lead agency or network provider.

The Role of the Lead:

The following specific service related decisions should be made in a collaborative manner with families, with final decision-making authority resting with lead agencies as described below:

- The selection of specific service models, providers, and community resources to work with a family/family member.
- The intensity and frequency of service receipt; changes in service providers working with a family/family member; and, for each service, duration and termination, whether because of success or ineffectiveness.
- The frequency and location of visitation with the family or intended caretaker. DSS will retain the authority for deciding whether visitation must be supervised.

- For children in their home, with the permission of the parent or guardian, short term respite including out-of-home settings.

DSS plans and promotes regular and frequent visitation with children-in-care with parents and siblings. The lead, in consultation with the family if appropriate, will be authorized to make decisions concerning the location and frequency of visitation. DSS will retain the authority for deciding whether visitation will be supervised. The lead will be responsible for providing that supervision either directly or through one of its network providers. When appropriate, the lead can recommend to DSS that it end the supervision requirement.

RECOMMENDATION 5: Educational Coordination in Relation to the Well-being of Children

In keeping with its charge to inform the system of care procurement and specifically the role of leads, the RG group included educational coordination as a key responsibility in its analysis because it is so critical to ensuring a child's well-being. Unlike other decisions in this report, authority for educational decision-making will depend not only on whether the child is in the DSS' care or custody, but on the type of educational program or services the child receives.

If a child is enrolled in a school program other than special education (for example, a regular education program, a program for language minority students, vocational education program), DSS has authority to make education decisions on behalf of a child in its custody. If a child is to be evaluated to determine whether he or she is eligible for special education, or the child has been found to be eligible for special education, neither DSS nor any provider involved in the care or control of the child may make special education decisions on behalf of the child. These decisions, such as consenting to a special education evaluation, accepting or rejecting an IEP, requesting a hearing to challenge a program or placement offered by a school district, can only be made by the child's parent or educational surrogate parent (ESP) appointed by a process recognized by the Massachusetts Department of Education (DOE). Practice guidelines developed by DSS and DOE state the general rule that parents will continue to be their children's educational decision maker when the child is placed voluntarily with DSS or is in DSS' custody through a CHINS proceeding. If the child's custody results from a care and protection, DSS will request that an ESP be appointed to act on the child's behalf.

In light of these rules and understandings, parents must be involved in many instances when special educational decision-making and advocacy take place. Even where not legally required, they should take part in educational matters involving their children whenever possible.

There is great benefit to the lead playing a central role in collaborating and coordinating with parents to achieve the greatest educational outcomes for children in all situations. Where DSS has authority to act in the educational arena, the lead could be authorized to make educational decisions in collaboration with the family as part of the service management decisions and case practice. Where special education decision-making is required, and the parent or an ESP must act on behalf of the child, particularly because of its role in service management, the lead too should have responsibility for collaborating and coordinating with the parent or ESP on special education matters.

[The RG listed medical advocacy as a decision point but did not address it as a recommendation; rather they saw it as part of case practice.]

RECOMMENDATION 6: Service Plan, Service Plan Revisions

Establishing and revising Service Plans should be a collaborative process with families and lead agencies, with ultimate responsibility resting with DSS.

Service Plans: Decisions relating to the Service Plan goal, outcomes and tasks should be retained by DSS. The RG held considerable discussion concerning both the initial and revised service plans. As part of clinical practice, the lead agency and family are seen as having an important role in making recommendations for the service plan. This is consistent with the underlying principle of engaging in team and consensus decision-making to the greatest extent possible. There is great benefit to involving the lead agency early in the service planning process to take advantage of its clinical and resource expertise in determining if purchased or non-purchased services are appropriate.

As the service plan currently exists, it is seen as a DSS document which acts as a tool and contract for working with families and is a central aspect of reporting to the courts. However, the RG felt that too often the service plan is not viewed as a flexible document that can be revised to meet the changing needs and situation of the child and family. Several members of the RG felt that for some aspects of service planning (particularly those related to tasks with respect to particular populations), a lead agency might be capable of assuming a decision-making role at some point in the future.

Role of the Family:

In keeping with the core values of DSS and the goal of family participation, the family has an important role in making recommendations about the service plan that will affect their lives. In partnership with the lead agency and DSS, the family will:

- Identify its own strengths and resources
- Identify service needs
- Recommend goals, outcomes, and tasks
- Request services that would be useful in achieving outcomes
- Identify kinship networks and community resources
- Provide feedback on quality of services provided

Role of the Lead:

The lead agency should play an important role in making recommendations to DSS and, when requested by DSS, convene the team for treatment planning in order to access purchased services and/or community resources.

The RG recognizes that service plans (including goals, outcomes and tasks) must be flexible. As the case progresses, they should be revised as the lead agency and network providers interact with the family and gain additional insight. Lead agencies are seen as key contributors to the ability to recognize in a timely way that a service plan needs to be revised to address new issues or lack of progress. With a format that all can understand and contribute to, the participation of the lead agency and family as recommenders enhances prospects that tasks will be successfully accomplished.

The social worker would make a single referral for services to the lead agency who would then be responsible for additional specific referrals for service.

Once DSS makes the decision that a meeting should be convened, the lead is responsible for treatment planning aspects of the service plan and identifying and coordinating attendance of core members. The lead will:

- Work with the family to identify kinship networks, augmenting the work of the social worker
- Solicit input from the family about who might participate in the planning meeting
- Help the family understand the service plan and implications of change
- Help to recommend goals, outcomes and tasks.

RECOMMENDATION 7: Change or consideration of change in the care and custody of a child.

DSS should make decisions concerning the change, or consideration of change, in the care and custody of a child.

This decision was clearly seen as being retained by DSS because of the department's knowledge and experience in carrying out its protective mandate, as well as court involvement/approval.

Role of the Family:

The family is consulted and involved in the decision-making process and makes recommendations concerning care or custody, including:

- Identify its own strengths and resources
- Identify their needs in terms of service and community support in order to have their child return home and to remain there successfully
- Provide information on kinship

Role of the Lead:

- The lead agency, and as appropriate network providers through the lead, plays an important role in making recommendations to DSS concerning changes or consideration of changes in custody or care of a child.
- The lead convenes the team including family members, appropriate treatment providers, and DSS.
- The lead, working with family, DSS and providers in its network, augments the work of the social worker in gathering information on the kinship network if not already identified.

RECOMMENDATION 8: Return of Custody, Permanency, and Case Closure

Because of DSS' protective mandate, the return of custody, permanency and closure of a case are based on significant risk assessment decisions, are supported by legal counsel, and may need court approval. Therefore the RG recommends that DSS retain decision-making related to these key areas.

Role of the Family:

With a family-centered practice, the family should be consulted and solicited for recommendations to the greatest extent possible. This includes:

- Identify its own strengths and resources
- Identify their needs in terms of service and community support in order to have their child return home and to remain there successfully
- Provide information on kinship placement
- Provide feedback on quality of services provided

Role of the Lead:

Where the lead agency has a working relationship and familiarity with a family, it could play an important role in the following decisions:

- With respect to return of custody, the lead should upon request by DSS, identify new members of the team and convene a meeting concerning return of custody.
- When the goal is reunification, work toward that goal in concert with the family and DSS. Work with the family to identify their strengths and what they need in terms of services to have their child return home.
- With respect to termination of parental rights, the lead should make recommendations based on its knowledge of the family situation and encourage family participation in decision-making.
- With respect to establishing permanency and identifying a permanent caretaker resource, the lead should work with parents and DSS to gather information on factors leading to permanency including recommendations on kinship placement.
- With respect to the end of DSS involvement, the lead should assist with natural and community supports because services may continue in the community after DSS closes the case.

Conclusion

The RG has made a number of general and specific recommendations about decision-making roles and responsibilities that it believes best support and advance the evolution of the system of care. The final recommendation relates to the process by which the RG developed its recommendations. The RG found that committing sufficient time to step away from the immediate press of their work enabled them to understand the assumptions, values, and strengths that each member brought to the relationship. While the specific structure and time commitment of 26 RG members meeting for nine day-long intensive conversations might not be replicable, the spirit and nature of the conversations is and should be a model for future conversations.

The RG's work was structured and led as a learning conversation and became a restorative conversation. The consensus process brought together a new group of individuals, many of whom did not know each other, and asked them to take on a previously unexplored set of issues, perhaps the most challenging issues (the power and authority to make decisions) that exist in child welfare practice. It is a testament to each member's commitment that this conversation produced the scope and substance of the recommendations that it did. That the passionate intensity in the conversation was a positive force, rather than a destructive one, is worth understanding and building on. Focusing on specific analytic work with the goal of producing recommendations for a specific purpose allowed the conversation to explore philosophical and value-laden issues in a grounded manner firmly connected to the reality of daily practice. The RG members learned about each other's worlds and perspectives; built mutual respect and understanding for each other's strengths; broke down barriers that contribute to misunderstanding and

often lead to blame; and built relationships that could be catalysts for further accomplishment in the future.

There are a number of relationships that would benefit from the lessons of the RG's experience. For each Area Office and the selected lead agency, engaging in a similar process to build shared values and discuss the intricacies of a true collaborative partnership will be an essential element in the success of the system of care. The same is true of the relationship that lead agencies build with their network providers. All the "paid professionals" who participated in the process noted that the most valuable voice in the conversation was that of families. RG members who participated in the Family Advisory Council meetings greatly appreciated the honest advice provided by family representatives. Continuing to find forums to bring the voice of families to the table is critical.

The end result of the RG's work is that the group became a community of practice, having built shared knowledge and expertise. Its members hope to continue to advise the Department and its partners in efforts to support the development of many more similar communities.

Appendix A

Recommendations Group Members

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Appendix B

Criteria for Making Recommendations

In discussing and arriving at recommendations, the RG agreed to apply the criteria listed below. The group agreed the language is aspirational in nature and that through implementation the System of Care should strive to meet these criteria.

Integrity

A healthy system of care respects and promotes the integrity of every individual and organizational participant. The authority to make decisions is central and critically necessary for any individual and organization to meet its obligations with integrity. Each participant must be supported in properly fulfilling their obligations in a manner that respects their partners' obligations and integrity. Do the recommendations for decision-making roles and responsibilities:

- Honor and support a family's and kinship network's executive functioning.
- Help to restore a healthy balance of involvement and accountability between communities and DSS.
- Honestly assess and make the most of provider agencies' experience, competency, and capacity to serve as lead agencies and hold decision-making responsibilities.
- Ensure DSS meets its obligations as the Commonwealth's public child welfare agency through an appropriate exercising of its authority that respects and values the input of family members and interested others.
-

Efficiency / Effectiveness

The time, skills, expertise, and efforts of DSS casework staff and managers, provider agency staff and managers, and family members are scarce resources in our system. They must be utilized in a manner that achieves results and promotes quality. Do the recommendations for decision-making roles and responsibilities:

- Allocate responsibility on both the family level and the aggregate network level in a manner that maximizes each partner's strengths, time, skills, and expertise
- Minimize duplication of effort, except where some redundancy is valuable to the health of the system.
- Eliminate gaps in responsibility.
- Promote time-sensitive decision-making.
- Promote timely access and implementation of services.
-

Variability

There is great variability in the provider community, the communities in which DSS works, and the families involved with DSS. How do the recommendations for decision-making roles and responsibilities support:

- Extended families, young families, older teens, foster families, pre-adoptive families, adoptive families, and cultural differences in family constellations.
- Small community agencies, minority business enterprises, large multi-service agencies, large single service agencies, local community partners, etc.
- Urban, suburban, and rural communities
- Different reasons for a family's involvement with DSS, particularly the degree to which safety risks are the primary concern.
- Development and support of community and service network capacity in order to meet families' needs.

Usability

The goal of the RG is to provide recommendations that can be utilized by DSS in the System of Care procurement.

- Does the recommendation support and advance DSS's child welfare philosophy and core practice values, especially as it relates to the primary role of the family?
- Is the recommendation clear and concrete enough to guide the development of the RFR for lead agencies?
- Is the recommendation actionable?
- Is the recommendation substantive and meaningful enough to be worth the required change efforts?

Feasibility

The recommendations should speak to both the world as it is as well as the world as the RG envisions.

- Does this recommendation fully capture and embrace all the strengths, resources and potential that the family brings to the table?
- Is the recommendation realistic given existing capacity in the current system?
- Does the recommendation identify the system components and capacities upon which its implementation is contingent?
- If what is feasible in the current context is less than desirable, does the recommendation identify steps that could be taken in order to advance the decision-making roles in the System of Care towards the desired goal?

Appendix C

Codes and Definitions for Responsibility Charting

- **D = Decides**: Determines and selects best option; signs off on implementation; accountable for the quality of the decision.
- **R = Recommends**: Takes the initiative in the particular area; analyzes the situation; develops alternatives; where appropriate, works to build consensus for the recommendation; makes the initial recommendation.
- **IM = Implements**: Accountable for implementation of the decision and notifying appropriate parties if decision cannot be implemented or a decision needs to be revisited.
- **C = Consulted**: Must be consulted prior to a decision being reached but with no veto power.
- **I = Informed**: Must be notified after a decision, but before it is publicly announced; someone who needs to know the outcome for other related tasks but need not give input.
- **DK = Don't Know**
- **Blank = No relationship**.